Roselle Park Board of Education
Roselle Park, NJ 07204

Epinephrine Auto Injector Procedure
for
Bee/Wasp/Stinging Insect Allergies or Food allergies

June 2016

Dear Parent/Guardian of ____________________,

You have informed us that your child, ______________, has a severe allergy to ___________________________. Since he/she may require the administration of epinephrine via an auto injector in the event of an anaphylactic reaction it is necessary to cooperatively develop a plan of action.

If able and age appropriate, the physician may choose to prescribe epinephrine to be self-administered by your child in the event of an anaphylactic reaction. Under specific circumstances, in the event that the student can not self-administer and if a certified school nurse is not available for the administration of the epinephrine auto injector, non-medical school personnel may be trained to administer the medication. **Only epinephrine** may be administered by the trained designee – other medications such as Benadryl may only be administered by the school nurse or self-administered by the student. #911 will be called immediately in the event of an emergency whether or not trained personnel are available.

It is your responsibility to inform the school of all after school and before school activities, sponsored by the Board of Education, in which your child participates in order for a trained designee to be present at the activity. You must update this information throughout the school year as activities change.

The attached forms must be completed by you, your child, if self-administering the medication, and the physician. A conference involving you, your child and pertinent school personnel may be organized once the attached forms are completed.

All efforts will be made to provide a safe and healthy environment for your child. Please do not hesitate to contact me with any questions, concerns or suggestions at (908) 241-4550, ext. 2071.

Yours truly,

Jan Haddad, RN, MSN
RPHS School Nurse

REV. 5/15

Roselle Park Public Schools
Roselle Park, NJ 07204
"Committed to Excellence"

RECOMMENDATION OF PRIVATE PHYSICIAN FOR STUDENT
SELF ADMINISTRATION OF
EPINEPHRINE AUTO INJECTOR OR
EPINEPHRINE AUTO INJECTOR WITH BENADRYL (Single unit dose)

TO BE COMPLETED BY THE PHYSICIAN:

In order to protect the health of ______________________________ Class ________________
(Student's name)
it may be necessary for him/her to use an Epinephrine Auto Injector in the case of anaphylactic shock.

Allergen: ____

Previous Symptoms: ____

☐ **Epinephrine Jr.** (0.15mg) IM ☐ **Epinephrine Sr.** (0.30 mg) IM

☐ **Auvi-Q** (0.15mg) ☐ Auvi-Q (0.30mg)

Side Effects: ______________________________

☐ **Benadryl** Dosage ________________ PO. Side Effects: ______________________________

The above named student has received instructions in the use of the Epinephrine Auto Injector with or without Benadryl and has demonstrated confidence and competence in self-administration. Failure to receive immediate medical treatment will result in a medical emergency. I, therefore, recommend that he/she be allowed to carry and self-medicate with the Epinephrine Auto Injector with or without Benadryl as described above.

__________________________ __________________________ ____________
Physician's Name (please print) Physician's Signature Date

TO BE COMPLETED BY THE PARENT:

I give permission for my child to self-medicate as described above. I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damages which may result to the student, his/her servants, and representatives which may result from administration of the medication. I will be fully responsible for keeping track of the expiration date of the medication and replacing it when it has expired.

MY CHILD ATTENDS THE ROSELLE PARK BOARD OF EDUCATION EXTENDED DAY PROGRAM____YES_____ NO

__________________________________ ____________ ________________
(Parent/Guardian Signatures) Date School

__________________________________ ____________ ________________
(Parent/Guardian Signatures) Date School

Roselle Park Board of Education

EMERGENCY HEALTH CARE PLAN

STUDENT'S NAME______________________________ D.O.B. ______________

GRADE _____ DESIGNEE___________________________ SCHOOL YEAR_____

ALLERGY TO:______________________________

STUDENT HAS HAD AN ANAPHYLACTIC REACTION IN THE PAST: ___YES ___ NO

Date of last anaphylactic episode: ______________

SIGNS OF AN ALLERGIC REACTION

Please indicate the patient's prior reactions:

_____ MOUTH	Itching and swelling of the lips, tongue, or mouth.
_____ THROAT	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough.
_____SKIN	Hives, itchy rash, and/or swelling about the face or extremities.
_____ABDOMEN	Nausea, abdominal cramps, vomiting, and/or diarrhea.
_____LUNG	Shortness of breath, repetitive coughing, and/or wheezing.
_____HEART	"Thready" pulse, "passing out."

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL THE ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

ACTION: Please circle action to be taken in the event of ingestion of allergen or insect sting/bite:

1. Epi-pen Jr. ----- Epi-pen Sr.
2. Call the rescue squad -----911.
3. Call: Parent #1 home____________ Parent #2 home______________

   work____________ work______________
4. Call: PHYSICIAN Dr.________________ at __________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

______________________ ______________

Parent Signature Date

M.D./D.O.______________________ ______________

Medical Provider Signature Date

3/04 bg

MEDICATION CONTRACT

Date:________ Name of Medication:________________________________

1. I understand that I will use this medication as directed by my physician.
2. I will carry the medication with me at all times, including outside during gym classes, on field trips, and at all athletic events. The medication will be easily accessible. I will be responsible in using it. I understand that if I do not have my medication with me during practices, games, events, etc. I will be excluded from participating in the activity.
3. I have been instructed how to self-administer this medication and understand the side effects and effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shared with anyone else.
4. I will notify teacher/supervisor/coach immediately upon use of the medication. 9-1-1 will be called. The School Nurse will be notified as soon as possible.
5. I understand that if I do not abide by the regulation, I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of the school year.

Student's Signature____ Date________________

Parent's Signature____ Date________________

11/14

Roselle Park Board of Education
Roselle Park, NJ 07204

DESIGNEE CONSENT FORM

STUDENT'S NAME:________________ **D.O.B.**__________ **CLASS**___________

DESIGNEE NAME: ____________________ **POSITION**_____________________
DESIGNEE NAME: ____________________ **POSITION**_____________________
DESIGNEE NAME: ____________________ **POSITION**_____________________
DESIGNEE NAME: ____________________ **POSITION**_____________________

TO BE COMPLETED BY DESIGNEE:

I/we consent to be designee(s) to administer the Epinephrine Auto Injector/Auvi-Q to the above named student in an emergency, in the absence of the school nurse. I/we agree to attend and complete training sessions by the school nurse. This consent is for the above named student only and is effective for this school year only.

________________________ _____________
Designee's Signature Date

________________________ _____________
Designee's Signature Date

________________________ _____________
Designee's Signature Date

________________________ _____________
Designee's Signature Date

TO BE COMPLETED BY PARENT/GUARDIAN:

☐ I hereby give my consent to permit___________________________ as the designated person in an emergency to administer the Epinephrine Auto Injector/Auvi-Q to my child, ______________________, in the absence of the school nurse. I further agree to indemnify and hold harmless the Roselle Park Board of Education and its school employees from any claims arising from administration of the Epinephrine Auto Injector to my child.

I have been informed and understand that the Roselle Park Board of Education has no liability as a result of any injury arising from the proper administration of the Epinephrine Auto Injector used for the emergency administration of the epinephrine to my child for anaphylaxis.

The permission for the emergency administration of epinephrine via auto injector to students for anaphylaxis is effective for the school year it is granted and must be renewed for each subsequent school year.

☐ I do not want non-medical personnel trained to administer the Epinephrine Auto Injector/Auvi-Q to my child, __________________________, in an emergency situation. Only the school nurse may administer the medication in an emergency. If the nurse is not available #911 will be called.

______________________________ __________
Parent/Guardian's Signature Date

To Parent/Guardian of: ______________________________________
From : Jan Haddad, RN, MSN
School Nurse

Re: **After School Activities and Epinephrine Auto-Injector**

Written orders have been received from your private physician stating that your child requires the administration of epinephrine for anaphylaxis. During the school day, the epinephrine may be self-administered, given by the school nurse or by a designee. After school, when the school nurse is not present, a trained epi-pen delegate should be available to administer the epinephrine.

According to Roselle Park Board of Education policy, it is the parent/guardians' responsibility to notify the school nurse and/or building principal in writing if their child attends any after school activities or programs sponsored by the Roselle Park Board of Education.

Please complete the following form and provide update as necessary.

Student Name________________________________

AFTER SCHOOL ACTIVITIES
1.___________________________
2.___________________________
3.___________________________
4.___________________________
5.___________________________
6.___________________________

Parent/guardian signature________________________________
Date____